



**E. DEPENDENTS AND NONDEPENDENTS**

Do you have any dependents?  Yes  No

Name of Dependent	Relationship to You	Age	Degree of Dependency (approx. %)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you are married, is spouse employed?  Yes  Full time  Part time  No

If no, is spouse able to obtain employment?  Yes  No (specify reason) \_\_\_\_\_

Please list all of your children, brothers, sisters and parents who are not listed under "Dependents" and provide the requested information for each one.

Name	Relationship	Age	Does This Person Live in Your Household?	Is This Person Able to Contribute to Your Support?	Indicate Amount Now Contributed Monthly
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____

Does anyone claim you as a dependent on a federal or state income tax return?  Yes  No

If yes, please provide the requested information for each one.

Name	Relationship	Degree of Support (approx. %)	Indicate Amount Now Contributed Monthly
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

**F. TOTAL ANNUAL INCOME OF APPLICANT, SPOUSE OR DEPENDENTS**

*(Be sure to answer each item – write “none” where applicable)*

	Received During Past Calendar Year	Expected During Current Calendar Year
Dental Practice: Gross Practice Income .....	1. \$ _____	1. \$ _____
Practice Expenses .....	2. \$ _____	2. \$ _____
Net Practice Income (Line F1 minus Line F2) ..	3. \$ _____	3. \$ _____
Other Occupation or Business Income .....	4. \$ _____	4. \$ _____
Retirement Distributions (IRA’s, Keogh, etc.) .....	5. \$ _____	5. \$ _____
Health and Accident Insurance Benefits .....	6. \$ _____	6. \$ _____
Disability Insurance Benefits .....	7. \$ _____	7. \$ _____
Social Security Benefits (OASI) .....	8. \$ _____	8. \$ _____
Veteran’s Compensation .....	9. \$ _____	9. \$ _____
Spouse’s Income .....	10. \$ _____	10. \$ _____
Interest and Dividends .....	11. \$ _____	11. \$ _____
Other Income (specify) .....	12. \$ _____	12. \$ _____
<b>Subtotal</b> (add Lines F3-F12) .....	13. \$ _____	13. \$ _____
ADAF Relief Grant ( <input type="checkbox"/> 12 mos. <input type="checkbox"/> 6 mos. <input type="checkbox"/> one-time) .....	14. \$ _____	14. \$ _____
		<b>(Applicant Please Leave Blank)</b>

**TOTAL INCOME** (add Line F13 and Line F14)..... **15. \$ \_\_\_\_\_**      **15. \$ \_\_\_\_\_**

ATTACH A COPY OF YOUR MOST RECENT FEDERAL INCOME TAX RETURN. IF YOU DO NOT FILE AN INCOME TAX RETURN, PLEASE SUBMIT A SIGNED WRITTEN STATEMENT ATTESTING TO THIS FACT.

**G. TOTAL ANNUAL EXPENSES OF APPLICANT, SPOUSE OR DEPENDENTS**

*(Be sure to answer each item – write “none” where applicable)*

Rental of House or Apartment .....		1. \$ _____
Home Maintenance (heat, utilities, etc.) .....		2. \$ _____
Mortgage Payments on Home .....		3. \$ _____
Real Estate Taxes .....		4. \$ _____
Food .....		5. \$ _____
Clothing .....		6. \$ _____
Health Care Not Covered by Insurance .....		7. \$ _____
Auto or Other Transportation .....		8. \$ _____
Income Tax Liability .....		9. \$ _____
Other Living Expenses (specify) .....		10. \$ _____
<u>Insurance Policies</u>	<u>Amount of Policy</u>	<u>Annual Premium</u>
Health, such as Blue Cross/Blue Shield .....		11. \$ _____
Hospital Indemnity .....		12. \$ _____
Homeowners/Renters .....		13. \$ _____
Disability .....	\$ _____	14. \$ _____
Accidental Death and Dismemberment .....	\$ _____	15. \$ _____
Life .....	\$ _____	16. \$ _____
Burial .....	\$ _____	17. \$ _____
Auto .....	\$ _____	18. \$ _____
Other (specify) _____	\$ _____	19. \$ _____
Total Annual Premiums (add Lines G11-G19) .....		20. \$ _____
<b>TOTAL EXPENSES</b> (add Lines G1-G10 and Line G20) .....		<b>21. \$ _____</b>

## H. BANK, S&L AND CREDIT UNION ACCOUNTS

(List bank accounts, certificates of deposit, money market accounts and savings accounts. If additional space is needed, please copy or download another worksheet.)

1. Name and Location of Bank	2. Type of Account	3. Balance
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

## I. REAL ESTATE

The legal and equitable title to all real estate listed in this statement is solely in the name of the undersigned, except as follows: \_\_\_\_\_

1. Description	2. Outstanding Mortgages or Liens	3. Monthly Payment	4. Assessed Value	5. Est. Fair Mkt. Value	If applicable, unpaid taxes:	
					6. Year	7. Amount
_____	\$ _____	\$ _____	\$ _____	\$ _____	_____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	_____	\$ _____

## J. OTHER LOANS

1. Loan Held By: (Name and Address)	2. Amount Of Loan	3. Amount Owing	4. Pay Off Date	5. How Endorsed Guaranteed or Secured
_____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____

## K. ACCOUNTS RECEIVABLE

(List the largest amounts owing to applicant and spouse)

Name and Address of Debtor	1. Amount Owing	2. Date Payment
		Expected
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

## L. LIFE INSURANCE

1. Name of Insured	2. Name of Beneficiary	3. Name of Insurance Co.	4. Type of Policy	5. Face Amount of Policy	6. Total Cash Surrender Value	7. Total Loans Against Policy	8. Is Policy Assigned?
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

## M. STOCKS, BONDS AND SECURITIES OF ANY TYPE

1. Face Value (Bonds) No. of Shares (Stocks)	2. Description Of Security	3. Present Market Value	4. Income Received Last Year	5. To Whom Pledged
_____	_____	\$ _____	\$ _____	_____
_____	_____	\$ _____	\$ _____	_____
_____	_____	\$ _____	\$ _____	_____

## N. RETIREMENT PLANS

(List any IRAs, 401(K), Keogh plans, profit-sharing or pension plans.)

1. Type	2. Most Recent Valuation	3. Date of Valuation
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____

## O. ASSETS AND LIABILITIES

Please answer all questions using "No" or "None" where necessary. Use totals from Sections G-O where applicable.

### ASSETS

(wholly or jointly owned by dentist or spouse)

- |   |          |
|---|----------|
| 1. <b>Cash</b> (Total Section H.3)  | \$ _____ |
| 2. <b>Real Estate</b> (Total Section I.5)   | \$ _____ |
| 3. <b>Accounts Receivable</b> (Total Section K.1)   | \$ _____ |
| 4. <b>Life Insurance, Cash Surrender Value</b><br>(Total Section L.6 – Do not deduct loans) | \$ _____ |
| 5. <b>Stock and Securities</b> (Total Section M.3)  | \$ _____ |
| 6. <b>Retirement Plans</b> (Total Section N.2)  | \$ _____ |
| 7. <b>Dental Practice</b> (including equipment)   | \$ _____ |
| 8. <b>Other Assets</b> (itemize)  | \$ _____ |
| 9.  | \$ _____ |
| 10.   | \$ _____ |
| 11.   | \$ _____ |
| 12.   | \$ _____ |
| 13. <b>Total Assets</b> (Add O.1–O.12)  | \$ _____ |

### LIABILITIES AND NET WORTH

(wholly or jointly owed by dentist or spouse)

- |  |          |
|--|----------|
| 14. <b>Other Loans</b><br>(Total Section J.3 – Direct borrowings only)       | \$ _____ |
| 15. <b>Loans Against Life Insurance</b> (Total Section L.7)                  | \$ _____ |
| 16. <b>Accounts Payable</b>  | \$ _____ |
| 17. <b>Real Estate Taxes Payable</b> (Total Section I.7)                     | \$ _____ |
| 18. <b>Income Tax Payable</b> (Total Section G.9)                            | \$ _____ |
| 19. <b>Outstanding Mortgages or Liens</b><br>(Total Section I.2)             | \$ _____ |
| 20. <b>Other Liabilities</b> (itemize)                                       | \$ _____ |
| 21.  | \$ _____ |
| 22.  | \$ _____ |
| 23. <b>Total Liabilities</b> (Add Lines O.14–O.22)                           | \$ _____ |
| 24. <b>Net Worth</b> (Line O.13 minus Line O.23)                             | \$ _____ |
| 25. <b>Total Liabilities and Net Worth</b><br>(Add Line O.23 plus Line O.24) | \$ _____ |

**P.** I have no assets or resources other than those disclosed in this application. I hereby authorize any person, firm, corporation, agency or institution to furnish the American Dental Association Foundation any and all information in its possession relative to my assets, deposits, dealings or business of any kind whatsoever, or concerning any matter affecting this application which the American Dental Association Foundation may desire.

**If this application is approved, please make grant checks payable to:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_  
(if other than applicant)

Signature: \_\_\_\_\_  
(application must be signed)

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**This Section To Be Completed By Component and/or Constituent Society Verifiers**

I personally interviewed the applicant and verified all the information contained in this application to be complete and accurate.

Date: \_\_\_\_\_

Signed: \_\_\_\_\_  
(component society verifier or designee)

Date: \_\_\_\_\_

Signed: \_\_\_\_\_  
(constituent society verifier)

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**Agreement to participate in grant**

This is to certify that \_\_\_\_\_ and \_\_\_\_\_  
(component society) (constituent society)

- recommend a:  new grant (6-month installments)  
 renewal grant (12-month installments)  
 emergency (single installment)

to: \_\_\_\_\_ in the sum of \$ \_\_\_\_\_  
(total aid requested)

and will contribute to the ADA Foundation the sum of \$ \_\_\_\_\_ in \_\_\_\_\_ monthly installments  
of \$ \_\_\_\_\_ each.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_  
(executive director, component society)

Date: \_\_\_\_\_ Signed: \_\_\_\_\_  
(executive director, constituent society)

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**For ADA Foundation use only**

Grant No. \_\_\_\_\_ Month and Year of First Grant \_\_\_\_\_

Month and Year Current Grant Expires \_\_\_\_\_



American Dental Association Foundation

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